BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
GLENN YUKIO MIYA, M.D.	)	Case No. 800-2014-006717
Physician's and Surgeon's Certificate No. G70876	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on August 14, 2019.

IT IS SO ORDERED July 15, 2019.

MEDICAL BOARD OF CALIFORNIA

By: Kristina Lawson

Kristina Lawson, JD, Chair
Panel B

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
BRIAN D. BILL
Deputy Attorney General
State Bar No. 239146
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6461
Facsimile: (213) 897-9395
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **GLENN YUKIO MIYA, M.D.** **9961 Sierra Avenue** **Medical Office Building - 2** **Fontana, CA 92335** **Physician's and Surgeon's Certificate No. G 70876,** Respondent.	Case No. 800-2014-006717 OAH No. 2018060165 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Brian D. Bill, Deputy Attorney General.

2. Respondent GLENN YUKIO MIYA, M.D. (Respondent) is represented in this proceeding by attorney Raymond J. McMahon, Esq., whose address is: 5440 Trabuco Road

Irvine, California 92620.

3. On or about March 4, 1991, the Board issued Physician's and Surgeon's Certificate No. G 70876 to GLENN YUKIO MIYA, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2014-006717, and will expire on July 31, 2020, unless renewed.

JURISDICTION

4. Accusation No. 800-2014-006717 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on October 24, 2017. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2014-006717 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2014-006717. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2014-006717, if proven at a hearing, constitute cause for imposing discipline upon his

Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he is to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

RESERVATION

12. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

13. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

14. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree that

the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 70876 issued to Respondent GLENN YUKIO MIYA, M.D. shall be and is hereby Publicly Reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand, which is issued in connection with Accusation No. 800-2014-006717, is as follows:

> In the course of the care and treatment of three patients, you failed to maintain adequate and complete medical records by failing to document discussions regarding the risks and potential complications of prescribed opioids. Further, as to one patient, you failed to recognize potential signs of abuse or diversion of prescribed opioids. These actions constitute repeated negligent acts.

1. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

2. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

//

//

//

//

//

//

//

//

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Raymond J. McMahon, Esq.. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: _____

GLENN YUKIO MIYA, M.D.
Respondent

I have read and fully discussed with Respondent GLENN YUKIO MIYA, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: _____

RAYMOND J. MCMAHON, ESQ.
Attorney for Respondent

//

//

//

//

//

//

//

//

//

//

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Raymond J. McMahon, Esq.. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: Jan. 4, 2019

GLENN YUKIO MIYA, M.D.
Respondent

I have read and fully discussed with Respondent GLENN YUKIO MIYA, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: January 4, 2019

RAYMOND J. MCMAHON, ESQ.
Attorney for Respondent

//

//

//

//

//

//

//

//

//

//

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 1-4-19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

BRIAN D. BILL
Deputy Attorney General
Attorneys for Complainant

LA2017605701
53205197.docx

Exhibit A

Accusation No. 800-2014-006717

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
CHRISTINA L. SEIN
Deputy Attorney General
State Bar No. 229094
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6481
Facsimile: (213) 897-9395
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Glenn Yukio Miya, M.D.** **9961 Sierra Avenue** **Medical Office Building - 2** **Fontana, CA 92335** **Physician's and Surgeon's Certificate No. G 70876,** Respondent.	Case No. 800-2014-006717 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about March 4, 1991, the Medical Board issued Physician's and Surgeon's Certificate Number G 70876 to Glenn Yukio Miya, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2018, unless renewed.

///

///

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, publicly reprimanded, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states in pertinent part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

". . . .

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"....

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

6. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022

without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

8. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of

the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

FACTUAL BACKGROUND

Patient D.W.[1]

9. Patient D.W. is a 42-year-old male who began receiving monthly prescriptions for Percocet[2] 5-325 mg from Respondent in July 2011. The reason for the prescription is unclear because the first progress note appearing in D.W.'s chart is dated more than a year later, on July 18, 2012. Thus, Respondent provided prescriptions for controlled pain medication for D.W. for at least one year before any indication for the treatment is documented in the record. Prescriptions for Percocet fluctuated between 5-325 mg and 10-325 mg. Tramadol 50 mg, a narcotic-like pain reliever, was added on February 22, 2012, but stopped on July 18, 2012 due to a "drug interaction." At this time, an examination of D.W.'s back was performed and he was diagnosed with sciatica.

10. In August 2012, D.W. began requesting refills for OxyContin,[3] however, the medical

[1] Patients are referred to by initials to protect privacy.

[2] Percocet is a brand name for a combination of acetaminophen and oxycodone. It is a Schedule II controlled substance.

[3] OxyContin is a brand name for oxycodone, an opioid pain medication. It is a Schedule II (continued...)

records do not indicate when D.W. began taking this medication and who initially prescribed it to him. Numerous telephone messages indicate that D.W. was calling Respondent for early refills of his pain medication because he was leaving town, or requesting higher doses because the medication allegedly was not effective.

11. On January 21, 2013, the patient presented with ongoing low back pain and reported he had sustained a fall on his stairs at home which was attributed to concomitant use of Ambien.[4] After a back examination, Respondent refilled Percocet 10-325 mg and referred the patient to pain management. The patient continued on Percocet, sometimes calling in to request a change to Vicodin.[5] An August 22, 2013 telephone message stated that D.W. wanted a refill of Vicodin because he could not get his Percocet until August 29, 2013 and that he needed something for pain. Respondent granted this request and refilled the prescription. At the next office visit on October 14, 2013, Respondent charts that he will refill D.W.'s Percocet "which ran out early," and that he will also prescribe "hydrocodone 10/325 q4 prn #40 to get by during this week."

12. On January 19, 2014, Respondent refilled D.W.'s Percocet, but also restarted amitriptyline 150 mg (an anti-depressant), prescribed Lidoderm (lidocaine) patches, and made mention of a possible referral to neurosurgery or a new pain management specialist. On February 13, 2014, Respondent indicates that D.W. was seen in urgent care on January 19, 2014 and was given Toradol (an NSAID), prednisone (a corticosteroid), and started on fentanyl 25 mcg.[6] Respondent also notes that D.W. had been seen in the emergency room for pain control, but was getting ready to leave on a cruise. The fentanyl was refilled that day and for the next several months.

13. Respondent continued to refill D.W.'s Percocet prescriptions over the next several months. On October 22, 2014, D.W. requested that a prescription for a three-month supply of

---

(...continued)
controlled substance.

[4] Ambien is a brand name for zolpidem, a sedative. It is a Schedule IV controlled substance.

[5] Vicodin is an opioid pain management drug that is a brand name for hydrocodone, a ketone derivative of codeine. It is a Schedule II controlled substance.

[6] Fentanyl is a Schedule II controlled substance.

Percocet be mailed to him. The request was granted and 540 tablets of Percocet were mailed to the patient.

Patient D.R.

14. Patient D.R. is a 57-year-old female who began seeing Respondent around 2000. She first presented with low back pain in September 2011. On July 23, 2012, Respondent prescribed Percocet 5-325 mg and refills were provided at regular monthly intervals. On January 23, 2013, Percocet dose was increased to 10-325 mg, however, there is no documentation to indicate why the increase was made. The highest strength of Percocet continued to be refilled intermittently over the next couple of years. Respondent continued to refill D.R.'s Percocet over the years and, as of July 8, 2015, Respondent was still prescribing Percocet to D.R.

Patient T.M.

15. Patient T.M. is an 83-year-old female who began seeing Respondent in 2000. On February 22, 2012, T.M. complained of a flare-up of her low back pain and stated that she was taking two to three Vicodin per day. Respondent provided a prescription for Vicodin on December 7, 2011, however, it is unclear why the prescription was provided.

16. On the July 19, 2012 visit, T.M. complained of shoulder pain and Respondent noted that she was taking three Vicodin and wanted to switch to the extra strength version. After a shoulder exam, Respondent changed the medication to Norco[7] 7.5-325 mg every 4 hours as needed.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts – Patients D.W., D.R., and T.M.)

17. Respondent Glenn Yukio Miya, M.D. is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts in his care and treatment of patients D.W., D.R., and T.M. The circumstances are as follows:

18. Complainant refers to and, by this reference, incorporates paragraphs 9 through 16, above, as though set forth fully herein.

[7] Norco is a brand name for a combination of acetaminophen and hydrocodone. It is a Schedule II controlled substance.

19. Per the 2003 guidelines for prescribing controlled substances for chronic pain, which were in effect at the time of Respondent's treatment, the standard of care provides that a medical history and physical examination must be accomplished. This includes an assessment of the pain, physical and psychological function; substance abuse history; history of prior pain treatment; an assessment of underlying or coexisting diseases or conditions; and documentation of the presence of a recognized medical indication for the use of a controlled substance.

20. The standard of care requires that a physician discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient.

21. The standard of care is that a physician should periodically review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the physician's evaluation of progress toward treatment objectives. If the patient's progress is unsatisfactory, the physician should assess the appropriateness of the continued use of the current treatment plan and consider the use of other therapeutic modalities.

22. The standard of care requires a physician to keep accurate and complete records, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic review of the treatment plan.

23. Respondent's treatment of patients D.W., D.R., and T.M., as set forth above in paragraphs 9 through 16, includes the following acts and/or omissions which constitute repeated negligent acts:

a. Respondent failed to properly document a history and physical establishing D.W.'s need for controlled substances.

b. Respondent failed to recognize and address the signs of misuse and abuse of controlled substances by D.W.

c. Respondent failed to maintain adequate documentation while treating D.W. and prescribing him controlled substances.

d. Respondent failed to provide informed consent to D.W. regarding the potential side effects of the controlled substances prescribed.

e. Respondent failed to provide informed consent to D.R. regarding the potential side effects of the controlled substances prescribed.

f. Respondent failed to provide informed consent to T.M. regarding the potential side effects of the controlled substances prescribed.

24. Respondent's acts and/or omissions as set forth in paragraph 23, above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts, pursuant to section 2234, subdivision (c), of the Code. Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Prescribing Without Exam/Indication – Patient D.W.)

25. Respondent's license is subject to disciplinary action under section 2242 of the Code, in that Respondent prescribed controlled substances to patient D.W. without an appropriate prior examination or medical indication therefor. The circumstances are as follows:

26. Complainant refers to and, by this reference, incorporates paragraphs 9 through 13, above, as though set forth fully herein.

27. Respondent's acts and/or omissions as set forth in paragraph 26, above, whether proven individually, jointly, or in any combination thereof, constitute prescribing without an appropriate prior examination or medical indication, pursuant to section 2242 of the Code. Therefore, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Excessive Prescribing – Patient D.W.)

28. Respondent's license is subject to disciplinary action under section 725 of the Code, in that Respondent excessively prescribed controlled substances to patient D.W. The circumstances are as follows:

29. Complainant refers to and, by this reference, incorporates paragraphs 9 through 13, above, as though set forth fully herein.

///

30. Respondent's acts and/or omissions as set forth in paragraph 29, above, whether proven individually, jointly, or in any combination thereof, constitute excessive prescribing, pursuant to section 2242 of the Code. Therefore, cause for discipline exists.

FOURTH CAUSE FOR DISCIPLINE

(Inadequate Record Keeping)

31. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate records concerning the care and treatment of patients D.W., D.R., and T.M. The circumstances are as follows:

32. The allegations of the First Cause for Discipline are incorporated by reference as if fully set forth herein.

33. Respondent's acts and/or omissions as set forth in paragraph 32, above, whether proven individually, jointly, or in any combination thereof, constitute failure to maintain adequate and accurate records, pursuant to section 2266 of the Code. Therefore, cause for discipline exists.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Repeated Failure to Participate in an Interview with the Board)

34. Respondent's license is subject to disciplinary action under section 2234, subdivision (h) of the Code, in that the Respondent failed, in the absence of good cause, to attend and participate in an interview with the Board, despite being the subject of an investigation by the Board. The circumstances are as follows:

35. Respondent was the subject of an investigation by the Board.

36. On or about May 18, 2017, the Board's investigator spoke with Respondent's attorney to schedule an interview with the Board, at which time the investigator was directed to call Respondent's attorney's secretary. The Board's investigator proposed several dates, however, the attorney's secretary provided only June 16, 2017 as a possible date, but could not confirm the date.

37. On May 30, 2017, the Board's investigator called Respondent's attorney's office to discuss scheduling the interview on June 16, 2017. Respondent's attorney's office advised that the attorney's secretary was unavailable until June 1, 2017.

38. On June 1, 2017, the Board's investigator called Respondent's attorney's secretary to schedule the interview for June 16, 2017, however, the secretary advised Respondent's attorney was not available because he was in trial.

39. On July 13, 2017, the Board's investigator sent an email to Respondent's attorney's secretary proposing several interview dates in July and August. On July 18, 2017, the Board's investigator sent an email to Respondent's attorney's secretary requesting confirmation of any of the interview dates in the July 13, 2017 email. On July 27, 2017, the Board's investigator sent another email to Respondent's attorney's secretary asking whether she could confirm an interview date on any of the August dates proposed in the July 13, 2017 email.

40. Respondent's attorney's secretary advised that the attorney was on vacation from the end of July until August 11, but that he was starting a trial on August 14 and would not be available until the week of September 5, 2017.

41. On August 28, 2017, the Board's investigator called Respondent's attorney's office regarding the interview, however, he was told the attorney was not in the office. The Board's investigator traveled to Respondent's residence to serve him with a subpoena to appear and testify, however, the resident who answered advised that Respondent was unavailable.

42. On August 29, 2017, the Board's investigator called Respondent's attorney's office again, however, he was told the attorney was in court all day. The Board's investigator traveled to Respondent's address of record with the Board and served Respondent with a subpoena to appear and testify at the Rancho Cucamonga field office on September 6, 2017 at 10:00 a.m.

43. On September 1, 2017, Respondent's attorney objected to the subpoena to appear and testify stating that he was engaged in trial. Respondent's attorney proposed dates in October 2017.

44. Respondent did not appear to testify on September 6, 2017.

45. Respondent's conduct, as set forth in paragraphs 35 through 44, above, constitutes unprofessional conduct pursuant to Code section 2234, subdivision (h), in that Respondent failed, in the absence of good cause, to attend and participate in an interview with the Board, despite being the subject of an investigation by the Board. As such, cause for discipline exists.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 70876, issued to Glenn Yukio Miya, M.D.;

2. Revoking, suspending or denying approval of Glenn Yukio Miya, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Glenn Yukio Miya, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: October 24, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

LA2017605701
62564139.doc